STATE OF CALIFORNIA – HEALTH AND WELFARE AGENCY

DEPARTMENT OF SOCIAL SERVICES
744 P Street, Sacramento, CA 95814
(916) 445-9537

11-4-80

ALL-COUNTY LETTER NO. 80-66

TO: ALL COUNTY WELFARE DIRECTORS

SUBJECT: NEW AND REVISED FOOD STAMP FORMS

REFFRENCE:

This letter transmits the first of several packages developed as a part of the statewide food stamp forms system. Included in this package are eight new and revised forms with instructions for the Eligibility Worker, an implementation schedule, a new policy governing the use of county-developed forms, and instructions for ordering state-printed forms.

The eight forms and instructions were developed as a joint effort by the Food Stamp Program Management Branch (FSPMB) and the CWDA Subcommittee on Food Stamp forms. In addition, comments received from other counties were considered in the development of the forms. The FSPMB believes that these forms represent a significant improvement over those currently in existence and appreciates the participation of the CWDA Subcommittee members and all others who contributed to the effort.

Attachment 1 provides a brief description of the purpose of each form and the major changes which were made. Copies of the forms themselves are also attached, along with instructions. These instructions were developed primarily as a training tool to assist counties in the transition to the forms. The instructions address key areas and are meant to supplement the Food Stamp Manual and individual county handbooks.

Implementation

One of the objectives of the FSPMB is to develop effective and efficient forms for county use, thereby promoting statewide standardized usage of forms. Such standardized usage is intended to result in improved county operations, consistent program application, equitable treatment of clients, and is consistent with the Department of Social Services (DSS) goal of establishing a statewide public assistance network. For this reason, each of the eight forms has been designated as required - no substitutes permitted, or as required - substitutes permitted with prior DSS approval.

Attachment 2 shows the specific designation and the implementation date of each form. Some of these forms are not currently referenced by the Food Stamp Manual, but regulations are in process to identify them and explain their use. In these cases, the implementation dates specified in Attachment 2 reflect the projected implementation date of the regulations. Those counties wishing to use any of the forms in this package, except the DFA 285-C and DFA 285-D, prior to the specified implementation dates, may do so as soon as supplies are available.

All counties will be required to use these forms as of the implementation dates unless a waiver is granted according to the procedure prescribed in Attachment 3. All existing approvals to use county-developed forms in place of any of the eight forms contained in this package are rescinded as of the implementation date of each form. Those counties on the case data system or other EDP systems which utilize computer-printed forms, are not required to use the forms in this package, but are required to make the necessary message modifications to ensure compliance with the form language by the prescribed implementation dates. Only those counties which can provide overriding justification of a county-specific situation will be allowed to modify required forms.

Ordering

Beginning with this forms package, the FSPMB is implementing a new process for form distribution. In the past, new and revised forms have been distributed directly to the counties based on FSPMB estimates of form usage. These estimates, however, did not always accurately reflect individual county form usage, storage limitations, or county printing capabilities. For this reason, the new procedure allows for forms to be printed and stocked in the warehouse for distribution based on individual county orders. All new and revised forms will be distributed in this manner unless the implementation date of a required form does not allow sufficient time to process county orders. In these cases, an interim supply of forms will be distributed directly to the counties.

Because of the number of forms included in this package and their varied implementation dates, Attachment 4 details the specific requirements for ordering these forms. Counties are requested to limit initial orders of these forms to a three-month supply. This request is necessary to ensure that all counties are provided with at least an interim supply of each form. After the initial distribution is made, statewide usage of the forms can be more accurately determined and sufficient quantities printed to accommodate larger orders.

Those counties choosing to print their own forms will be provided with camera-ready copies, and may begin using the forms as soon as their supplies are available. If county printing time frames will not provide the forms by the specified implementation dates, an interim supply should be ordered from the DSS warehouse. Please contact Linda Gregory at (916) 445-9537 to request the camera-ready copies.

Should you have any questions about the use of these forms, the implementation dates or require additional training on the procedures described herein, please contact th. Food Stamp Program Operations Bureau.

KYLE S. McKINSEY
Deputy Director

Atch.

cc: CWDA

DESCRIPTION OF FORMS AND MAJOR CHANGES

DFA 285-A Application for Food Stamps

The DFA 285-A is the food stamp application form completed by households when first applying for food stamps and at recertification. Part I of the application is used to initiate the application process and to identify households requiring expedited service. Part II is used to gather information to determine the household's eligibility for food stamps.

The application for food stamps has been revised to more completely document the determination of an applicant's eligibility for food stamps. In addition to gathering the applicant information, verification is documented as well as other items such as the applicant's choice of actual or averaged income, the choice of the standard utility rate or actual utility cost, voluntary quit, income exemptions and work registration exemptions. This provides a much clearer connection between the applicant information on the application and the amounts entered on the budget worksheet, which contains documentation of the final eligibility determination. The application also reflects several regulation changes concerning Social Security numbers, student status, shelters for battered persons, handicapped vehicles and the reduced resource limit. Additional instructions will be provided regarding the specific implementation of these changes.

DFA 285-B Food Stamp Budget Worksheet

The DFA 285-B is used in conjunction with an application for food stamps to document a household's eligibility for food stamp benefits. The budget portion of the worksheet is used for computing the benefit level for one month, and for a second month if required by an anticipated or actual change during the certification period. The change portion of the worksheet is used to record any nonbudgetary changes which occur during the certification period.

The Food Stamp Budget Worksheet contains two major changes. The first is a change in design which allows for a two-month budget calculation to accommodate either an actual or anticipated change during the certification period. The second is the addition of a change worksheet for documenting nonbudgetary changes occurring during the certification period. This form replaces TEMP DFA 1-B.

DFA 285-C Food Stamp Application - Special Medical Deductions

The DFA 285-C is a supplementary food stamp application form completed by a household with a member who is (1) 60 years of age or older, or (2) receiving Social Security disability payments for his/her own disability. The application gathers information required to calculate special medical deductions for these individuals.

The Food Stamp Application - Special Medical Deductions has been revised as a result of the final regulations for this provision which consider the insured portion of a medical expense. The column "Paid by Household" has been added to assist in capturing the required information.

DFA 285-D Food Stamp Budget Worksheet - Special Medical/Shelter Deductions

The DFA 285-D is the worksheet used to document eligibility for food stamp benefits for households with a member who is (1) 60 years of age or older, or (2) receiving Social Security disability payments for his/her disability. The worksheet is used in conjunction with an application for food stamps and the DFA 285-C Food Stamp Application - Special Medical Deductions. The budget portion of the worksheet is used for computing the benefit level for one month, and for a second month if required by an anticipated or actual change during the certification period. The change portion of the worksheet is used to record any nonbudgetary changes which occur during the certification period.

The Food Stamp Budget Worksheet - Special Medical/Shelter Deductions has been revised to be consistent with the design and content of the Food Stamp Budget Worksheet (DFA 285-B) as well as to compute allowable medical expense deductions.

DFA 377.1 Food Stamp Notice of Action and Right to Request a State Hearing

The DFA 377.1 is used by the Eligibility Worker to notify a household of the status of its food stamp case. It is used to notify households of approval actions, what additional information is needed for a pending case, denial or termination actions, changes in food stamp benefit amounts within the certification period, and reasons for the intended action(s), with the appropriate Food Stamp Manual section noted.

This form may be used in certain circumstances instead of the old DFA 377.3 (Food Stamp Notice of Eligibility, Denial or Pending Status) and obsoletes the DFA 377.4 (Food Stamp Notice of Adverse Action).

DFA 377.2 Food Stamp Notice of Expiration of Certification and Right to Request a State Hearing

The DFA 377.2 is used by the Eligibility Worker to notify a food stamp household of the expiration date of its current certification period, and other specific information about recertification.

This form has been revised to more accurately reflect the time during which an applicant may reapply for food stamps without a break in benefits.

DFA 377.3 Food Stamp Notice of Approval/Food Stamp Notice of Expiration of Certification and Right to Request a State Hearing

The DFA 377.3 is used by the Eligibility Worker to notify a household of the approval of food stamp benefits and the expiration of the certification period. This form may be used instead of the DFA 377.1 and the DFA 377.2 for short certification periods where a Notice of Expiration is sent at the same time as a Notice of Approval.

This form combines parts of the old DFA 377.2 and the old DFA 377.3 to provide a single Notice of Action for short certification periods.

DFA 377.9 Notice of Restoration of Lost Food Stamp Benefits and Right to Request a State Hearing.

The DFA 377.9 is used by the Eligibility Worker to notify a food stamp household of its eligibility for restoration of lost benefits and, if applicable, of the offsetting of such benefits by unpaid claims.

This is a new form.

Attachment 2

IMPLEMENTATION

No.	Title	Required Form: No Substitutes	Required Form: Substitutes Allowed	Form Replaces	Implementation Date
DFA 285-A (9-80)	Application for Food Stamps	X		DFA 285-A (2-79)	1/1/81+
DFA 285-B (9-80)	Food Stamp Budget Worksheet		X	Temp DFA 1-B (4-79)	1/1/81+
DFA 285-C (8-80)	Food Stamp Application - Special Medical Deductions	X		DFA 285-C (1-80)	12/1/80
DFA 285-D (9-80)	Food Stamp Budget Worksheet - Special Medical/Shelter Deductions		X	DFA 285-D (1-80)	12/1/80
DFA 377.1 (9-80)	Food Stamp Notice of Action	X		DFA 377.3 (2-79) DFA 377.4 (2-79)	2/1/81*
DFA 377.2 (9-80)	Food Stamp Notice of Expiration of Certification	X		DFA 377.2 (4-79)	2/1/81
DFA 377.3 (9-80)	Food Stamp Notice of Approval/ Notice of Expiration of Certification	X		DFA 377.2 (4-79) DFA 377.3 (2-79)	2/1/81*
DFA 377.9 (9-80)	Notice of Restoration of Lost Food Stamp Benefits		X	None	2/1/81

*Implementation dates for the DFA 377.1, and DFA 377.3 are estimates as they are contingent upon the final filing of regulations. Counties will be notified of actual implementation dates via an All-County Letter.

+Counties choosing to use the revised DFA 285-A and the new DFA 285-B prior to the prescribed implementation dates, should implement the two forms simultaneously because of the interdependence of the documentation requirements.

Note: Spanish versions of these forms are being translated and will be implemented as supplies become available. Existing Spanish forms should be used until the revised forms are available.

FORM MODIFICATION REQUESTS

Policy:

To ensure statewide standardized usage of food stamp forms, the following policy concerning county form modification requests has been adopted by FSPMB.

1. The state shall develop and revise forms required for the administration of the Food Stamp Program and designate those forms as (1) required - no substitutes, (2) required - substitutes permitted, or (3) recommended, in accordance with DSS definitions for form designation, as outlined in the DSS County Forms Catalog. County modification of state-required forms is subject to DSS review and approval in accordance with prescribed criteria.

2. The counties shall submit to DSS for review and comment any county-developed form used instead of a state-developed form designated as recommended or used because no state-developed form exists. (Does not include county internal operation forms).

Criteria for Form Modification:

Manual Section 63-300.2 specifies that overprinting of required forms for the following purposes is acceptable and does not require prior state approval:

1. To identify CWD.
2. To add information to "County Use Only" section.
3. To add EW instructions.

For any form designated as "required", DSS will consider county form modifications to accommodate the physical requirements of an EDP system.

In addition, the following modifications will be considered for forms designated as required - substitutes permitted:

- Additions to collect statistical data required by the county.
- Additions other than overprinting for county instructions.
- Other additions required by an overriding county-specific situation, so long as the resulting modification does not change the program intent or legal content of the form and the need for the modification can be adequately justified.

Procedure:

- Required Forms

  Any county needing to modify a required form for one of the reasons specified above, shall submit a written request to the FSPMB Program Operations Bureau.

To be considered for approval, the request shall contain, as a minimum, a letter specifying the state form which is being modified, a description of the proposed changes, an explanation of the need for the changes, and a copy of the proposed form modification. In cases where the proposed modification is the result of an overriding county-specific situation, a detailed justification for the change must be submitted for the request to be considered.

. Recommended Forms, Other County-Developed Forms

State forms designated as recommended which are modified by the county and other county-developed forms for which there is no state form (except county internal operation forms) shall be submitted for review and comment to the Program Operations Bureau. A letter containing the information outlined above for required forms shall accompany a copy of the proposed modification of a recommended state form. Other proposed county-developed forms shall be submitted with a letter explaining their need and describing their use. All forms will be reviewed for effectiveness, efficiency (cost savings) and proper application of program requirements.

All form modification requests will be reviewed by the Program Operations Bureau, the FSPMB Forms Committee, and, if necessary FNS, to ensure that the modifications are consistent with this policy and the overall objectives of the FSPMB. Counties will be informed of the results of the review no later than 30 days after submission of the request. Approval will be granted on a county-by-county basis, and will be based upon the individual merit of each county's justification for the change. Once approval is granted, the form waiver will remain in effect until the state form is revised or obsoleted.

County adherence to the policies concerning form usage and modification will be monitored by the Department, exceptions will be noted, and corrective action required.

FORM ORDERS

Orders for the forms contained in this package should be submitted on the GEN 727B according to normal procedures, except as follows:

1. Specify in the description of the form the latest revision date (noted below) to ensure that the order is not filled with old stock.

2. Submit orders after receiving a GEN 127 which will be notification that the stock has been received by the DSS warehouse.

3. Limit initial orders to a three-month supply.

The following information is provided to assist counties complete the GEN 727B.

Form No.	Title	Revision Date	Unit of Issue	Date Stock Available	Implementation Date
DFA 285-A	Application for Food Stamps	9/80	Each	12/1/80	1/1/81
DFA 285-B	Food Stamp Budget Worksheet	9/80	Pad/100	12/1/80	1/1/81
DFA 285-C	Application for Food Stamps-Special Medical Deductions	8/80	Pad/100	Now Available*	12/1/80
DFA 285-D	Food Stamp Budget Worksheet-Special Medical/Shelter Deductions	9/80	Pad/100	Now Available	12/1/80
DFA 377.1	Food Stamp Notice of Action and Right to Request a State Hearing	9/80	Sets	1/1/81	2/1/81 +
DFA 377.2	Food Stamp Notice of Expiration of Certification and Right to Request a State Hearing	9/80	Sets	1/1/81	2/1/81
DFA 377.3	Food Stamp Notice of Approval/ Food Stamp Notice of Expiration of Certification and Right to Request a State Hearing	9/80	Sets	Now Available	2/1/81 +
DFA 377.9	Notice of Restoration of Lost Food Stamp Benefits and Right to Request a State Hearing	9/80	Sets	1/1/81	2/1/81

* An interim supply has been shipped directly to the counties. Additional stock may be ordered from the warehouse as needed.

+ Implementation dates are estimates and are contingent upon the filing of final regulations.

APPLICATION FOR FOOD STAMPS
PART I

FOR COUNTY USE ONLY

COUNTY

CASE NUMBER

DATE RECEIVED

Step 1. Complete Page 1

To begin to apply for food stamps, you can complete this first page, tear it off and give it to us. We are required to take action on your application within 30 days from the date you give us this first page. So, the sooner you give us the first page, the quicker you will know whether you will receive food stamps. Now go to Step 2.

Step 2. Complete Pages 2 – 6

Pages 2–6 must be completed before we can see if you're eligible for food stamps. You can return pages 2–6 to us along with the first page or at the time of the interview we will schedule for you. Try to fill out as much as possible now. Your case worker will help you with the rest during the interview.

YOUR NAME (LAST, FIRST, MIDDLE INITIAL)

TELEPHONE NUMBER WHERE YOU CAN BE REACHED

MAILING ADDRESS (NUMBER, STREET, ROUTE NUMBER) CITY STATE ZIP CODE

IF YOU DON'T HAVE A STREET ADDRESS, TELL US HOW TO GET TO YOUR HOME

SIGN HERE

TODAYS DATE

If You Need Food Stamps Right Away

If your household (you and the people who live and eat with you) has little or no income right now, you may be able to receive food stamps within a few days. Answer the following questions only if your household has little or no income and needs food stamps right away:

1. HAS ANYONE IN YOUR HOUSEHOLD RECEIVED ANY INCOME SO FAR THIS MONTH?

☐ YES ☐ NO IF YES, HOW MUCH? $

2. DID YOUR HOUSEHOLD'S ONLY INCOME RECENTLY STOP? (IF YOUR HOUSEHOLD HAS NOT RECENTLY RECEIVED ANY INCOME, CHECK YES)

☐ YES ☐ NO

3. DOES ANYONE IN YOUR HOUSEHOLD EXPECT TO RECEIVE INCOME LATER THIS MONTH?

☐ YES ☐ NO ☐ DON'T KNOW IF YES, HOW MUCH? $ WHEN?

4. HOW MANY PEOPLE LIVE IN YOUR HOME AND EAT WITH YOU? (INCLUDE YOURSELF)

5. HOW MUCH DO THE MEMBERS OF YOUR HOUSEHOLD HAVE IN CASH AND SAVINGS? (GIVE YOUR BEST ESTIMATE OF THE TOTAL)

$

APPLICATION FOR FOOD STAMPS
PART II

IMPORTANT:

Answer the following questions honestly and completely. If you know but refuse on purpose to give any needed information, your household (you and the people who live and eat with you) will not be eligible for food stamps. You may complete this form at home and mail it or bring it to the food stamp office; or another member of your household or an adult who knows you may complete and return it to us. If you need more space please attach another sheet of paper.

COUNTY USE ONLY

WORKER NUMBER

CASE NUMBER(S)

☐ NEW APPLICATION
☐ RECERTIFICATION
☐ EXPEDITED SERVICE

DATE RECEIVED

(1) YOUR NAME

TELEPHONE NUMBER WHERE YOU CAN BE REACHED

MAILING ADDRESS | CITY | STATE | ZIP CODE

RESIDENCE ADDRESS (IF NO .E, TELL US HOW TO GET TO YOUR HOME)

WORK REGISTRATION DATE OR WORK EXEMPTION CODE

DOCUMENTATION GUIDELINES

A ALIEN STATUS, STUDENT STATUS, SSN APPLICATION, ETC. IS ANY HH MEMBER 60 YEARS OLD OR DISABLED

(2) **INSTRUCTIONS:** Fill in all blanks for each household member, including yourself. List people who live and eat with you. DO NOT list roomers, boarders or people receiving Supplemental Security Income (SSI). For each person who is not a citizen, you may need to show an alien registration card.

	BIRTHDATE / /	U.S. CITIZEN	STUDENT	
1. NAME				
* SOCIAL SECURITY NUMBER	CIRCLE SEX M F	YES ☐ NO ☐	YES ☐ NO ☐	
2. NAME	BIRTHDATE / /	U.S. CITIZEN	STUDENT	
* SOCIAL SECURITY NUMBER	CIRCLE SEX M F	YES ☐ NO ☐	YES ☐ NO ☐	
3. NAME	BIRTHDATE / /	U.S. CITIZEN	STUDENT	
* SOCIAL SECURITY NUMBER	CIRCLE SEX M F	YES ☐ NO ☐	YES ☐ NO ☐	
4. NAME	BIRTHDATE / /	U.S. CITIZEN	STUDENT	
* SOCIAL SECURITY NUMBER	CIRCLE SEX M F	YES ☐ NO ☐	YES ☐ NO ☐	
5. NAME	BIRTHDATE / /	U.S. CITIZEN	STUDENT	
* SOCIAL SECURITY NUMBER	CIRCLE SEX M F	YES ☐ NO ☐	YES ☐ NO ☐	
6. NAME	BIRTHDATE / /	U.S. CITIZEN	STUDENT	
* SOCIAL SECURITY NUMBER	CIRCLE SEX M F	YES ☐ NO ☐	YES ☐ NO ☐	
7. NAME	BIRTHDATE / /	U.S. CITIZEN	STUDENT	
* SOCIAL SECURITY NUMBER	CIRCLE SEX M F	YES ☐ NO ☐	YES ☐ NO ☐	

(3) **INSTRUCTIONS:** List all other people living in your home. This includes roomers, boarders, people receiving Supplemental Security Income (SSI) or any other person not listed above.

1. NAME	3. NAME
2. NAME	4. NAME

WORK EXEMPTION CODE

A. UNDER 18/60 OR OVER
B. MENT/PHYS. DISABLED
C. CARES FOR INCAP/CHILD UNDER 12
D. CARES FOR UNDER 18 AND HH MEMBER REG/EMP.
E. WIN
F. RECEIVES UIB
G. IN ADDICT/ALCOHOL PROG.
H. 30 HR WK/MIN. X 30

* DISCLOSURE OF SOCIAL SECURITY NUMBERS IS REQUIRED FOR EACH HOUSEHOLD MEMBER AGE 18 OR OLDER OR UNDER 18 WITH COUNTABLE INCOME. OUR AUTHORITY TO REQUEST YOUR SOCIAL SECURITY NUMBER IS REGULATION MPP SECTION 63–404. YOUR SOCIAL SECURITY NUMBER WILL BE USED TO IDENTIFY YOU, TO MATCH YOU WITH OTHER FILES, AND TO DETERMINE PROGRAM EFFECTIVENESS. REFUSAL TO PROVIDE IT WILL RESULT IN A DENIAL OF YOUR APPLICATION.

COUNTY USE ONLY

(4) **ROOMERS AND BOARDERS:** Does anyone pay you for meals and/or a room? ☐ YES ☐ NO
If YES, complete the following:

NAME	MEALS, ROOM, BOTH	HOW MUCH	HOW OFTEN?	# OF MEALS PER DAY?
1.		$		
2.	MEALS, ROOM, BOTH	$		

DO YOU PAY SOMEONE ELSE FOR MEALS AND/OR A ROOM? ☐ YES ☐ NO
IF YES, COMPLETE THE FOLLOWING:

NAME	MEALS, ROOM, BOTH	HOW MUCH	HOW OFTEN?	# OF MEALS PER DAY?
1.		$		
2.	MEALS, ROOM, BOTH	$		

(5) **PREPARED MEALS**

ARE YOU OR YOUR SPOUSE UNABLE TO PREPARE MEALS BECAUSE OF YOUR HEALTH PROBLEMS?
☐ YES ☐ NO

IF YES, DO YOU RECEIVE MEALS FROM EITHER
A. MEALS ON WHEELS PROGRAM ☐ YES ☐ NO
B. A COMMUNAL DINING FACILITY ☐ YES ☐ NO

ARE YOU, OR IS ANOTHER HOUSEHOLD MEMBER A MEMBER OF A DRUG ADDICT OR ALCOHOLIC REHABILITATION TREATMENT CENTER OR RESIDING IN A SHELTER FOR BATTERED PERSONS?
☐ YES ☐ NO IF YES, GIVE NAME OF PERSON AND CENTER/SHELTER.

DO YOU/THEY LIVE THERE? ☐ YES ☐ NO

RESOURCES

(6) Does any member of your household have any of the resources listed below? Check each item. Resources DO NOT include your home, household goods, pension funds, cash value of life insurance policies, or personal items (books, clothes, etc.)

	YES	NO	CURRENT VALUE	AMOUNT OWED	INCOME PRODUCING? YES	NO
A. SAVINGS ACCOUNT	☐	☐	$			
B. CHECKING ACCOUNT	☐	☐	$			
C. CREDIT UNION ACCOUNT	☐	☐	$			
D. CHECKS OR MONEY (at home or elsewhere)	☐	☐	$			
E. REAL ESTATE (other than home)	☐	☐	$	$	☐	☐
F. BOATS	☐	☐	$	$	☐	☐
G. TRAILERS	☐	☐	$	$	☐	☐
H. NOTES, MORTGAGES, TRUST DEEDS, SALES CONTRACTS	☐	☐	$		☐	☐
I. TRUST FUNDS	☐	☐	$		☐	☐
J. STOCKS, BONDS, CERTIFICATES	☐	☐	$		☐	☐
K. OTHER (specify)	☐	☐	$	$	☐	☐
	☐	☐	$	$	☐	☐

(7) Does anyone in your household own any cars, trucks, vans, campers, motorcycles or other vehicles? ☐ YES ☐ NO
If YES, complete the following for each vehicle. Look at your registration to find the year, class, make and model of each vehicle you own.

MOTOR VEHICLES	VEHICLE	VEHICLE	VEHICLE
YEAR/CLASS			
MAKE & MODEL			
ESTIMATED VALUE			
AMOUNT OWED			
LICENSED (Circle)	YES NO	YES NO	YES NO

TOTAL RESOURCES
$_____

COUNTY USE ONLY – VEHICLES

(A)	VEHICLE		VEHICLE		VEHICLE	
HOME, INCOME PRODUCING OR HANDICAP?	YES ☐	NO ☐	YES ☐	NO ☐	YES ☐	NO ☐
UNDER $4500 PER TABLE?	☐	☐	☐	☐	☐	☐
EXEMPT? FOR H.H. USE?	☐	☐	☐	☐	☐	☐
WORK, SEEK WORK, SCHOOL, TRAIN?	☐	☐	☐	☐	☐	☐

(B) VALUES		
FMV		
MINUS 4500		
EXCESS VALUE		
FMV		
MINUS ENCUMBRANCE		

(8) Did you or any member of your household sell, trade or give away anything of substantial value during the last three months? ☐ YES ☐ NO If YES, explain:

COUNTY USE ONLY
DOCUMENTATION GUIDELINES

VERIFY ALL INCOME AND LIST TYPE OF DOCUMENTATION USED. NOTE EXEMPT SOURCES OF INCOME. NOTE DATES OF ALL PAYSTUBS USED.

INCOME

(9) Fill in all blanks for each household member with a full or part-time job. If a member has more than one job, list each job separately. Include members who receive income from CETA, WIN or other training program. For your interview, please bring pay stubs or other proof of wages.

A. WAGES

NAME OF WAGE EARNER	NAME OF EMPLOYER	GROSS AMOUNT (TOT. BEFORE DEDUCTIONS)	(✓) HOW OFTEN PAID? WEEKLY	EVERY 2 WEEKS	TWICE MONTHLY	MONTHLY	(✓) IF EX-EMPT	(✓) STUBS VIEWED
1.								
2.								
3.								

B. SELF-EMPLOYMENT

Is anyone in your household self-employed? ☐ YES ☐ NO if YES, give their names.

You must provide proof of self-employment costs and income.

CLIENT ELECTS:
☐ AVERAGED INCOME
☐ ACTUAL INCOME

C. Has anyone in your household quit a job in the last 60 days? ☐ YES ☐ NO

VOLUNTARY QUIT?
☐ YES ☐ NO

(10) Do you or any household member receive income from any of the sources listed below? Check each item YES or NO. If YES, complete the additional information needed. For your interview, bring proof of income for which you have checked YES below.

SOURCE OF INCOME	(✓) YES	NO	HOUSEHOLD MEMBER WHO RECEIVES THIS INCOME	AMOUNT OF EACH CHECK OR PAYMENT	(✓) HOW OFTEN RECEIVED: WEEKLY	EVERY 2 WEEKS	TWICE MONTHLY	MONTHLY	(✓) IF EXEMPT
A. AFDC (AID TO FAMILIES WITH DEPENDENT CHILDREN)	☐	☐							
B. SOCIAL SECURITY BLUE/GREEN CHECKS	☐	☐							
C. SSI (SUPPLEMENTAL SECURITY INCOME) - GOLD CHECKS	☐	☐							
D. GA (GENERAL ASSISTANCE) OR GR (GENERAL RELIEF)	☐	☐							
E. VA (VETERANS BENEFITS)	☐	☐							
F. UNEMPLOYMENT OR DIB OR WORKERS COMPENSATION	☐	☐							
G. PENSIONS OR RETIREMENT INCOME	☐	☐							
H. A. SCHOLARSHIP, GRANTS, LOANS FOR SCHOOL B. TUITION, MANDATORY FEES $_____	☐	☐							
I. CHILD SUPPORT AND ALIMONY	☐	☐							
J. MONEY FROM FRIENDS OR RELATIVES (OTHER THAN LOANS)	☐	☐							
K. LOANS	☐	☐							
L. GROSS INCOME FROM PROPERTY	☐	☐							
M. OTHER (SPECIFY)	☐	☐							

(11) Have you or anyone in your household applied for or do you expect to receive income from any of the sources listed in 10? ☐ YES ☐ NO If YES, explain:

COUNTY USE ONLY

(12) Does anyone in your household pay for someone to babysit or care for a child or disabled adult so that a member can work, attend training or look for a job?
☐ YES ☐ NO If YES, complete the following:

WHO PROVIDES THE CARE? NAME:	HOW MUCH DO YOU PAY?	HOW OFTEN?

(13) Complete the amount and how often you are billed for each of the housing costs you have.

		AMOUNT	HOW OFTEN?
A.	RENT	$	
B.	MORTGAGE PAYMENT	$	
C.	PROPERTY TAXES (If not included in mortgage)	$	
D.	FIRE INSURANCE ON HOME (If not included in mortgage)	$	
E.	OTHER	$	

(14) **UTILITIES**

CLIENT ELECTS:
☐ ACTUAL ☐ STANDARD

Check the box next to the utility cost you pay and list the amount you are billed and how often you are billed. The state standard utility amount may be used to compute your benefits if you are billed for gas/electricity. If your utility bills are higher than the state standard amount, you may receive more food stamps. Bring verification for any amounts listed below.

		(✓)	AMOUNT	HOW OFTEN?
A.	GAS FOR HEATING AND COOKING	☐	$	
B.	ELECTRICITY	☐	$	
C.	WATER	☐	$	
D.	SEWER	☐	$	
E.	GARBAGE AND TRASH	☐	$	
F.	TELEPHONE (BASIC RATE)	☐	$	
G.	OIL	☐	$	
H.	INSTALLATION OF UTILITIES	☐	$	
I.	OTHER	☐	$	

(15) Does anyone pay or help you pay any of the housing or utility bills you have listed in 13 or 14 above?
☐ YES ☐ NO If YES, explain:

(16) The law requires that information on ethnic origin and primary language be collected. However, the information will not affect your eligibility for aid. If you do not complete this section the eligibility worker will make this judgment.

My ethnic group is (check one box only)

- ☐ WHITE (NOT OF HISPANIC ORIGIN)
- ☐ HISPANIC
- ☐ BLACK (NOT OF HISPANIC ORIGIN)
- ☐ ASIAN OR PACIFIC ISLANDER
- ☐ AMERICAN INDIAN OR ALASKAN NATIVE
- ☐ FILIPINO
- ☐ OTHER (SPECIFY)

My language is (check one box only):
(If you can speak and understand English, check English)

- ☐ ENGLISH
- ☐ SPANISH
- ☐ CHINESE
- ☐ JAPANESE
- ☐ KOREAN
- ☐ VIETNAMESE
- ☐ FILIPINO (TAGALOG)
- ☐ OTHER (SPECIFY)

ETHNIC ORIGIN			
WH	H	B	AP
1	2	3	4
A1	F		
5	7		

PRIMARY LANGUAGE			
SP	CH	J	K
1	2	3	4
T	O	E	
5	6	7	

(17) You can authorize someone outside your household to get your Food Stamps for you or to use them to buy food for you. If you would like to authorize someone, complete below.

NAME OF AUTHORIZED REPRESENTATIVE	ADDRESS	TELEPHONE NUMBER

(18) CERTIFICATION

Your rights:

You have a right to a hearing if you are not satisfied with the action taken on your application by the Welfare Department. You may discuss the action with the County Welfare Department staff and if you are not satisfied with the discussion, you may request a hearing by the Department of Social Services. The request may be written or oral and must say why you are not satisfied. The request must be received by the Office of the Chief Referee, DSS, 744 P Street, Sacramento, California 95814, within 90 days of the postmarked date of the Notice of Intended Action with which you are dissatisfied.

Nondiscrimination:

This application will be considered without regard to race, color, age, religious creed, national origin, political beliefs, handicap or sex. If you believe you have not been treated like everyone else, talk to the County Welfare Department. If you are not satisfied with their actions and want to file a complaint, write to Department of Social Services, 744 P Street, Sacramento, CA 95814 or call toll free 1-800-952-5253. The toll free Teletypewriter (TTY) number is 1-800-952-5434.

YOUR RESPONSIBILITIES:

You must inform the County Welfare Department within 10 days of any of the following changes.

- Your new address if you move.
- Changes in the number of people in your household.
- Increase in resources (cash on hand, savings and/or checking accounts, bonds, land, buildings, cars, campers, boats, etc.), whenever the total amount or value owned is more than $3,000 for households with 2 or more persons and at least 1 is age 60 or older; or $1,500 for all other households.
- A car, or other licensed vehicle, if anyone in your household gets one.
- Changes in your total household income when it goes up or down by $25 or more a month. You don't have to report changes in your AFDC check.
- Your new rent or mortgage costs if you move.
- Medical expenses if they go down by more than $25 a month.

If you plan to move to another county or state it may be possible for you to transfer your food stamp eligibility with you PROVIDED that you report the move to this food stamp office before you move and you obtain a transfer document FNS-286.

PENALTY WARNING:

If your household receives food stamps, it must follow the rules listed below. Any member of your household who breaks any of these rules on purpose can be barred from the food stamp program; fined, imprisoned, or both and subject to prosecution under other applicable laws.

DO NOT Give false information, or hide information, to get or continue to get food stamps.

DO NOT Trade or sell food stamps or authorization cards.

DO NOT Alter authorization cards to get food stamps you're not entitled to receive.

DO NOT Use food stamps to buy ineligible items, such as alcoholic drinks and tobacco.

DO NOT Use someone else's food stamps or authorization cards for your household.

YOUR PLEDGE:

I understand the questions on this application and the penalty for hiding or giving false information or breaking any of the rules listed in the penalty warning. My answers are correct and complete to the best of my knowledge.

I understand that I may have to provide documents to prove what I've said. I agree to this. If documents are not available I agree to give the name of a person or organization the food stamp office may contact to obtain the necessary proof. I will also cooperate fully with county, state and federal personnel in a quality control review.

YOUR SIGNATURE: ▶	DATE
WITNESS, IF YOU SIGNED WITH AN "X"	
SIGNATURE (AUTHORIZED REPRESENTATIVE OR OTHER PERSON COMPLETING APPLICATION	DATE
If an authorized representative completes application attach written authorization of head of household or spouse.	
IF SIGNED BY "X" SIGNATURE OF WITNESS	DATE
SIGNATURE OF INTERVIEWING WORKER	DATE APPLICATION REVIEWED WITH CLIENT OR AUTHORIZED REPRESENTATIVE.

Form Instructions
(for Eligibility Worker)

Application for Food Stamps

Purpose:

The DFA 285-A is the food stamp application form completed by households when first applying for food stamps and at recertification. Part I of the application is used to initiate the application process and identify households requiring expedited services. Part II is used to gather information to determine the household's eligibility for food stamps. The application also contains information for the household concerning hearing rights, reporting responsibilities, and a notice of penalty for the fraudulent receipt or use of coupons.

Preparation:

Part I - 1st Section (Applicant Identification)

Manual Section: 63-300.2, 63-301.1

An application is considered to be filed when it is received with the following information by the appropriate CWD office:

1. Applicant's name.
2. Applicant's address.
3. Household member or authorized representative signature.

When an application with the above information is received, enter the date of receipt in the space provided. This date begins the 30-calendar-day period during which an eligible household must be given the opportunity to participate, unless a CA-1 was completed before this date. In this case the date of the CA-1 begins the 30-calendar-day period.

Part I - 2nd Section (Expedited Services)

Manual Section 63-301.5

If the applicant completes this section, review the responses to questions 1, 2, and 3 to identify whether the applicant should be referred for expedited services After reviewing these questions in the following order, the answers to questions 4 and 5 should then be considered. If the number of household members and the income (questions 1 and 4), or the amount of resources (question 5) indicate that the household would not be eligible for food stamps, refer for normal processing.

1. If question 1 is "No" and question 3 is "No" or "Don't Know" - refer for expedited services.

2. If question 2 is "No" - Do not refer for expedited services. Stop - Do not go to question 3.

3. If question 2 is "Yes" - go to question 3.

4. If question 3 is "No" or "Don't Know" - refer for expedited services.

5. If question 3 is "Yes" and

   - Income will not be received within the next 10 calendar days - refer for expedited services.
   - Income of $25 or less will be received within 10 calendar days - refer to expedited services.
   - Income of more than $25 will be received within 10 calendar days - do not refer to expedited services.

Part II

Question	Manual Section	Information Requested	EW Action
County Use Only	63-300.5	N/A	Complete requested information. Date received is the date Part II is received. Check box if application is new, recertification, or expedited services and follow appropriate verification requirements.
1		Household name and address.	None.
2	63-404	Household member	SSN - Delete from the household any member not complying with the Social Security number requirements. (Note exception for expedited services.)
	63-502.3		Sixty/Disabled - Note if any household member is 60 years of age or older or disabled, and document that a DFA 285-C was given to the household. Allow excess shelter costs and medical deductions for any household with such a member.
	63-300.512 63-300.522 63-403		Alienage/Citizenship - Note if any household member is an alien and document the type of verification provided to determine the alien's eligible status. Note if a CA-6 was completed by the household and sent to INS. Delete from the household any member whose citizenship is questionable and verification has not been received within two months.

Question	Manual Section	Information Requested	EW Action
	63-406		Student - Note if any household member is between 18 years of age & 60 years of age, physically and mentally fit, and a student enrolled at least half time in an institution of higher education. Apply student eligibility criteria.
	63-407		Work Registration - For all household members exempted from work registration, note the work exemption code in the space provided. For all other household members, note in the space provided the date a completed DE 8435 or DE 8435V is submitted.
3	63-402.2 63-402.7	Nonhousehold members.	Check that each person listed here meets the criteria to be considered a nonhousehold member.
4	63-402.2	Roomers and Boarders.	Check the status of each person listed here to determine eligibility as a boarder.
5	63-402.4 63-503.56	Drug addict/alcoholic treatment center members. Battered persons centers.	Check the place of residence for each person listed here to determine eligibility as a household member.
6	63-501.1 63-501.4 63-501.7 63-503.54	Resources.	Document resources, making appropriate exclusions. Check status of nonhousehold members to determine if resources should be excluded.
7	63-501.51	Motor vehicles.	Evaluate vehicles for resource exemption. Document evaluation in county use only section A. For all nonexempt vehicles compute values in Section B. Enter in the space provided the total resource amount.
8	63-501.6	Transfer of resources.	Check circumstances of any resource transfers to determine if program eligibility is affected.

Question	Manual Section	Information Requested	EW Action
9A	63-300.511 63.502.1 63-502.2 63-503.5	Wages.	For each source of earned income, check if exempt in the box provided. Also for each source, check the box provided when pay stubs have been viewed and note the date and amount. Check the appropriate box for actual or averaged income.
9B	63-502.1 63-502.2 63-503.5	Self-employment.	Compute earned income from self-employment using cost and income information provided by the household. Check the approprite box for actual or averaged income.
9C	63-407.7	Voluntary quit.	If checked yes, determine if action meets criteria for voluntary quit. Check yes or no in the county use only section.
10	63-300.511 63-502.1 63-503.5	Unearned income.	Check that each income source is checked yes or no. For all yes answers, check that all other information is provided. In the space provided, check any income amount which is exempt. Document verification of gross nonexempt income in county use only section.
11	63-502.2 63-503.22 63-503.5	Anticipated income.	Document in the county use only section whether or not income is considered anticipated for purposes of the budget calculation.
12	63-502.34 63-503.23	Dependent care.	If checked yes, consider for a dependent care income deduction.
13	63-502.35 63-503.23	Shelter costs.	Calculate allowable shelter deductions.
14	63-300.513 63-502.36 63-502.353 63-503.23	Utilities.	Indicate if the household elects actual or standard allowance for utilities by checking the appropriate box in the county use only section. Document verification when actual utility costs are used.

Question	Manual Section	Information Requested	EW Action
15	63-502.2 63-503.23	Vendor payments.	Determine if any such payments should be excluded from the household income.
16		Ethnic origin and primary language.	Circle appropriate code in county use only section for ethnic origin and primary language.
17	63-402.6	Authorized representative.	Include name of authorized representative on household identification card.
18		Certification.	Check that the application contains all required signatures.

FOOD STAMP BUDGET WORKSHEET

CASE NAME | CASE NUMBER | CERTIFICATION PERIOD FROM ____ THROUGH ____

	EFFECTIVE MONTH	☐ ANTICIPATED CHANGE ☐ ACTUAL CHANGE EFFECTIVE MONTH	VERIFICATION /EXPLANATION
A. NONEXEMPT AMOUNTS OF GROSS EARNED INCOME			
1. Gross Salary, Wages	$	$	
2. Self–Employment (From DFA 285.1)			
3. Training Allowance			
4. Total Gross Earned Income (A1 + A2 + A3)			
5. 80% of Line A4	$	$	
B. NONEXEMPT AMOUNTS OF GROSS UNEARNED INCOME			
1. Total Assistance Grant	$	$	
2. Social Security /UIB / DIB			
3. Child Support or Alimony			
4. Prorated Scholarships, Grants, Loans (From J4)			
5. Other Unearned Income			
6. Total Gross Unearned Income (B1 + B2 + B3 + B4 + B5)			
7. Total Adjusted Gross Income (A5 + B6)	$	$	
C. INCOME DEDUCTIONS			
1. Standard Deduction	$	$	
2. Dependent Care (Lesser of Actual or Maximum)			
3. Total Income Deductions (C1 + C2)			
4. Net Income (B7 – C3)	$	$	
D. SHELTER DEDUCTION COMPUTATION (If C2 is at maximum, skip D1 – D6 and enter 0 in D7)			
1. Total Shelter Cost (Total Housing and Utilities from F Below)	$	$	
2. Allowable Shelter Cost (50% of C4)			
3. Excess Shelter (D1 – D2)			
4. Maximum Allowance for Dependent Care and Shelter			
5. Allowable Dependent Care Deduction (From C2)			
6. Maximum Excess Shelter Deduction (D4 – D5)			
7. Excess Shelter Deduction (Lesser of D3 or D6)	$	$	
E. NET MONTHLY INCOME (NMI) (C4 – D7)	$	$	

F. SHELTER COSTS

Housing	1st Month	2nd Month
Rent or Mtg.	$	$
Taxes		
Insurance		
Other		
Total	$	$

Utilities	1st Month	2nd Month
Gas	$	$
Electric		
Water		
Sewer		
Garbage		
Telephone		
Other		
Total	$	$

G. ALLOTMENT

	1st Month	2nd Month
Net Monthly Income	$	$
No. in Household		
Allotment		

H. SUPPLEMENTAL ONLY

Previous Auth.	$	$
Amount of Supp.		

ELIGIBILITY WORKER SIGNATURE	DATE	ELIGIBILITY WORKER SIGNATURE	DATE
SUPERVISOR SIGNATURE	DATE	SUPERVISOR SIGNATURE	DATE

DFA 285–B (9/80)Required Form – Substitutes Permitted

HOUSEHOLD INFORMATION/DISPOSITION

APPLICATION DATE	☐ APPROVED ☐ DENIED ☐ PENDING		REASON/REMARKS
	1ST MONTH	**2ND MONTH**	
Classification	☐PA ☐NA ☐MIXED (NA)	☐PA ☐NA ☐MIXED (NA)	HOUSEHOLD ADDRESS
Issuance	[ ]ATP/HIR [ ]DIRECT [ ]ES	[ ]ATP/HIR [ ] DIRECT	
ETHNIC CODE	COMPANION CASE REFERENCE	PRIMARY LANGUAGE	AUTHORIZED REPRESENTATIVE

I. EDUCATIONAL GRANTS, SCHOLARSHIPS, LOANS

VERIFICATION/EXPLANATION

1. Income received from educational grants, etc. $ _____
2. Tuition and mandatory fees _____
3. Subtract Line 2 from 1 _____
4. Prorate Monthly Amount (Enter on Line B4) $ _____

CHANGE WORKSHEET – For Nonbudget Changes Within the Certification Period

A. RESOURCES (Do not enter the value of excluded resources)

VERIFICATION/EXPLANATION

Cash On Hand	$
Savings Accounts	
Checking Accounts	
Stocks, Bonds, Etc.	
Nonexcluded Real Estate	
Countable Value of Licensed Vehicles (See below)	
Equity Value of Unlicensed Vehicles	
Other	
Total	$

B. ADDRESS CHANGE

C. AUTHORIZED REPRESENTATIVE CHANGE

D. HOUSEHOLD MEMBER CHANGES	WORK REGISTRATION NECESSARY	IF YES, DATE REG. IF NO, CODE	SOCIAL SECURITY NO. OR SSA 5028 DATE
1.	☐ Yes ☐ No		
2.	☐ Yes ☐ No		
3.	☐ Yes ☐ No		
4.	☐ Yes ☐ No		
5.	☐ Yes ☐ No		

E. CITIZENSHIP/ALIEN VERIFICATION

F. MOTOR VEHICLE CHANGES

1.	Vehicle	Vehicle	Vehicle
Year			
Make and Model			
Estimated Value	$	$	$
Amount Owed	$	$	$
Licensed	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
2. Home, Income Producing or Handicap?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Under $4500 Per Table	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Exempt? For Household Use?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
For Work, Seek Work, School, Train?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

3. For Licensed Vehicles, the greater value (excess or equity) is the resources amount.

For Unlicensed Vehicles, the equity is the resources value.

Fair Mkt. Value		
Minus $4500		
Excess Value		

Fair Mkt. Value		
Minus Encumbr.		
Equity Value		

If under $4500 and exempt, stop here. If not, go to 3.

Type of Change					
Eligibility Worker (Initial) / Date					
Effective Date					

Form Instructions
(for Eligibility Worker)

Food Stamp Budget Worksheet

Purpose:

The DFA 285-B is used in conjunction with an application for food stamps to document a household's eligibility for food stamp benefits. The budget portion of the worksheet is used for computing the benefit level for one month and for a second month if required because of an anticipated or actual change during the certification period. The change portion of the worksheet is used to record any nonbudgetary changes which occur during the certification period.

Note: The DFA 285-D, Food Stamp Budget Worksheet - Special Medical/Shelter Deductions should be used for any household containing a member who is (1) 60 years of age or older, or (2) receiving Social Security disability payments for his/her disability.

Preparation:

Enter the following identifying information on the top of the front page of the worksheet:

- Case name
- Case number

Enter the beginning and ending dates of the certification period; month and year.

Enter the effective month for the first month budget calculation and complete the budget.

Section A. Nonexempt Amounts of Gross Earned Income

1. Enter nonexempt gross earnings from employment.

2. Enter earnings from self-employment from self-employment worksheet(s).

3. Enter all training allowance received.

4. Add items A1, A2, and A3 and enter total.

5. Calculate 80 percent of the amount on Line A4 and enter.

Section B. Nonexempt Amounts of Gross Unearned Income

1. Enter nonexempt amount of all assistance grants received.

2. Enter nonexempt income from Social Security, railroad retirement, unemployment insurance, disability insurance, pensions, etc.

3. Enter all child support or alimony payments received.

4. Enter amount of all scholarships, grants, and loans from Line I4.

5. Enter all other nonexempt unearned income received by the household.

6. Add Lines B1, B2, B3, B4 and B5 and enter total.

7. Add Lines A5 and B6 and enter total.

Section C. Income Deductions

1. Enter amount of standard deduction.

2. Enter the amount of dependent care not to exceed the maximum.

3. Add Lines C1 and C2 and enter total.

4. Subtract Line C3 from B7 and enter the remainder.

Section D. Shelter Deduction

Note: If C2 is at the maximum, skip D1 through D6 and enter a zero (0) on Line D7.

1. Enter the total shelter cost as calculated in Section F.

2. Enter 50 percent of Line C4.

3. Subtract Line D2 from D1 and enter the remainder.

4. Enter the maximum allowable for both dependent care and excess shelter.

5. Enter amount claimed for dependent care from C2.

6. Subtract D5 from D4 and enter amount.

7. Enter the lesser amount, D3 or D6.

Section E. Net Monthly Income

Subtract D7 from C4 and enter the remainder.

Section F. Shelter Costs

Complete this section to determine if there are excess shelter costs.

Enter actual housing costs and total.

Enter actual utility costs if household elects actual. Enter state utility standard allowance or state standard telephone deduction if applicable. Total utilities.

Section G. Allotment

Enter the net monthly income from Section E and the number of household members from the application. Using the current tables of coupon issuance enter the household's allotment.

Section H. Supplemental Only

Complete this section if the budget was calculated because of a change and resulted in a supplemental issuance. Enter previous authorization and amount of supplement.

Signature Block

Enter EW signature and date after completing budget. Enter EW supervisor signature and date after review of budget calculation and allotment.

Second - Month Budget

If a second-month budget is calculated, enter the effective month, check if the budget calculation is being made because of an anticipated or actual change, and complete as outlined for the first month budget.

Household Information/Disposition

Enter the application date and disposition of the application. If denied or pending, enter reason. Explain a concurrent approval/denial in the remarks section.

Enter the requested household information, i.e., household classification and type of issuance, ethnic code, companion case reference, primary language, household address and authorized representative.

Section I. Educational Grants, Scholarships, Loans

Complete this section if the household has income from educational grants, scholarships or loans.

1. Enter total amount of all educational grants, etc.

2. Enter amount of tuition and mandatory fees.

3. Subtract Line 2 from Line 1 and enter remainder.

4. Divide Line 1 by number of months the educational grant, etc., is intended to cover. Enter this amount on Line B4.

Change Worksheet

For each nonbudgetary change, enter the date the change occurred and the date the change was reported in the verification/explanation column.

Section A. Resources

Enter any change in resource amounts and total. Determine if household still meets the maximum resource standard.

Section B. Address Change

Self-explanatory.

Section C. Authorized Representative Change

Self-explanatory.

Section D. Household Member Changes

Enter the following information for each new household member.

- Full name of the household member.
- Check (✓) if the household member is required to register for work.
- Date the household member registered for work or the work exemption code.
- Household member's Social Security number or the date the household member applied for a Social Security number.

Based on number of household members, determine new coupon allotment.

Section E. Citizenship/Alien Verification

List the document(s) used to verify legal status.

Section F. Motor Vehicle Changes

Use this section to record household motor vehicle changes. Each vehicle must be treated separately to determine its countable resource amount. Thereafter, each amount is added to determine the total vehicle resource amount.

1. Year: Self-explanatory.

   Make and Model: Self-explanatory.

   Estimated Amount: Determine from the blue book, CPI book, newspapers, etc.

   Amount Owed: Self-explanatory.

   Licensed (circle): Circle yes or no if the motor vehicle registration fees are paid for the current year. If not, skip Part 2 and go directly to Part 3.

2. For licensed vehicles, check (✓) yes or no if the vehicle is used as a home, is income producing, or is a vehicle for a handicapped individual.

   Exempt?: Check (✓) if any vehicle is exempt for the reasons shown.

   If the fair market value of any vehicle is over $4,500 and not exempt from equity determination, proceed to Part 3.

3. For remaining licensed vehicles, the greater value (excess or equity) is the countable vehicle resource amount. Calculate as follows:

   - Enter the fair market value of the vehicle.
   - Enter $4,500.
   - Subtract $4,500 from the fair market value and enter remainder under excess fair market value.
   - Enter the fair market value again for the same vehicle.
   - Enter the amount of encumbrance.
   - Subtract the encumbrances from fair market value and enter remainder under equity value.

Change Signature Block

Complete this section each time a nonbudgetary change is recorded on the worksheet during the certification period.

- Enter the type of change, EW initials and date.

STATE OF CALIFORNIA – HEALTH AND WELFARE AGENCY

DEPARTMENT OF SOCIAL SERVICES

FOOD STAMP APPLICATION – SPECIAL MEDICAL DEDUCTIONS

INSTRUCTIONS

This Food Stamp Application for Special Medical Deductions is to be completed for any household member who is 1) 60 years of age or older; or 2) receiving Social Security disability payments as a disabled person, regardless of age. DO NOT list persons receiving Supplemental Security Income (gold check) or spouses or dependents entitled under the disability beneficiary provision.

FOR COUNTY USE

CASE NAME

CASE NUMBER

(1) NAME	BIRTHDATE MO. DAY YR.	DOES THIS PERSON RECEIVE A DISABILITY PAYMENT?
		☐ YES ☐ NO
		☐ YES ☐ NO
		☐ YES ☐ NO

(2) MEDICAL EXPENSES

Give the following information for ONLY those persons listed above. List expenses for which you are currently billed. Do not include past due billings. (Check YES or NO if entire bill has been or will be paid by the household. Attach bills for all items listed.)

MEDICAL EXPENSE ITEM	HOUSEHOLD MEMBERS WHO RECEIVED SERVICES	HOW OFTEN?	AMOUNT BILLED	PAID BY HOUSEHOLD YES	PAID BY HOUSEHOLD NO
a. Medical or dental care provided by a certified practitioner.					
b. Hospitalization or outpatient treatment, and nursing care.					
c. Prescribed drugs.					
d. Health and hospitalization insurance policy premiums.					
e. Medicare premiums; Medi–Cal share of costs and/or spend down expenses.					
f. Dentures, hearing aids and prosthetics. Prescribed medical supplies and equipment.					
g. Seeing eye or hearing dog expenses, including the cost of dog food and veterinarian bills.					
h. Eye glasses and contact lenses. prescribed by a physician or optometrist.					
i. Cost of transportation and lodging to obtain medical treatment or services.					
j. Maintaining an attendant necessary due to age, illness or infirmity.					
k. The number and cost of meals furnished to an attendant.					
l. Other (specify)					

PENALTY WARNING

If anyone in your household intentionally hides or gives any false information as requested above, they may be barred from the Food Stamp Program and be fined, imprisoned or both.

CERTIFICATION

I understand the questions on this form. I also understand the penalty for hiding or giving false information. My answers are correct and complete to the best of my knowledge. I agree to provide documents to prove what I've said. If the requested documents are not readily available, I agree to give the name of a person or organization the food stamp office may contact to obtain the necessary proof.

SIGNATURE	DATE	WITNESS (IF SIGNED WITH AN "X")	DATE

SIGNATURE (AUTHORIZED REPRESENTATIVE OR OTHER PERSON COMPLETING APPLICATION)	DATE

I HAVE GIVEN MY AUTHORIZED REPRESENTATIVE PERMISSION TO COMPLETE THE INFORMATION ON THIS FORM

SIGNATURE OF HEAD OF HOUSEHOLD OR SPOUSE	DATE	WITNESS (IF SIGNATURE WITH AN "X")	DATE

SIGNATURE OF WORKER WHO REVIEWED THIS APPLICATION	DATE

Form Instructions
(for Eligibility Worker)

Application for Food Stamps - Special Medical Deductions

Purpose:

The DFA 285-C is a supplementary food stamp application form completed by a household member who is (1) 60 years of age or older, or (2) receiving social security disability payments for his/her own disability. The application gathers information required to calculate special medical deductions for these individuals. The form is required only for those household's entitled to claim excess medical expense deductions, unless they choose not to.

Preparation:

Question No.	Manual Section	Information Requested	EW Action
County Use Section	N/A	N/A	Enter case name and case number.
1	63-502.33	Eligible Household Members	Check that each household member named is at least 60 years of age or receiving a social security disability payment. Check that the social security payment received is for the household member's own disability.
2		Medical Expenses	Determine the allowability of each item of medical expense as follows:
	63-502.33		1. Check that each household member receiving services is an eligible household member listed in question 1.
	63-502.33 63-503.231		2. Check that each amount shown is for an allowable item of expense.
	63-300.515		3. Verify the amount of any deductible medical expenses and note the specifics of the verification in the county use section.

Question No.	Manual Section	Information Requested	EW Action
	63-502.33		4. Identify which items of expense are insured, uninsured, and which items (if any) are hospital bills, and document in the county use section. Determine the applicable amount for each deduction.
	63-503.23		5. Determine which items of expense are recurring, one-month-only, or should be averaged over the certification period.
		Certification	Check that the application contains all required signatures.

FOOD STAMP BUDGET WORKSHEET – Special Medical/Shelter Deductions

CASE NAME | CASE NUMBER | CERTIFICATION PERIOD FROM ____ THROUGH ____

	EFFECTIVE MONTH	☐ ANTICIPATED CHANGE ☐ ACTUAL CHANGE EFFECTIVE MONTH	VERIFICATION /EXPLANATION
A. NONEXEMPT AMOUNTS OF GROSS EARNED INCOME			
1. Gross Salary, Wages	$	$	
2. Self–Employment			
3. Training Allowance			
4. Total Gross Earned Income (A1 + A2 + A3)			
5. 80% of Line A4	$	$	
B. NONEXEMPT AMOUNTS OF GROSS UNEARNED INCOME			
1. Total Assistance Grant	$	$	
2. Social Security /UIB /DIB			
3. Child Support or Alimony			
4. Prorated Scholarships, Grants, Loans (From E4)			
5. Other Unearned Income			
6. Total Gross Unearned Income (B1 + B2 + B3 + B4 + B5)			
7. Total Adjusted Gross Income (A5 + B6)	$	$	
C. INCOME DEDUCTIONS			
1. Standard Deduction	$	$	
2. Dependent Care (Lesser of Actual or Maximum)			
3. Excess Medical Expenses (From F6)			
4. Subtotal Income Deductions (C1 + C2 + C3)			
5. Shelter Costs (From G3c)			
6. Total Income Deductions (C4 + C5)	$	$	
D. NET MONTHLY INCOME (NMI) (B7 –C6)	$	$	

E. EDUCATIONAL GRANTS, SCHOLARSHIPS, LOANS

1. Income Received From Educational Grants, Etc. $ ____
2. Tuition and Mandatory Fees ____
3. Subtract Line 2 From 1 ____
4. Prorate Monthly Amount (Enter on Line B4) $ ____

F. MEDICAL EXPENSES

ALLOWABLE AMOUNTS	1st Month	2nd Month
1. Recurring Expenses	$	$
2. One–Month–Only Expenses		
3. Averaged Expenses (Over Cert. Period)		
4. Total Allowable Expenses		
5. Less $35		
6. Excess Medical Expenses (Enter on Line C3)	$	$

G. SHELTER COSTS

1. Housing	1st Month	2nd Month
Rent or Mtg.	$	$
Taxes		
Insurance		
Other		
Total	$	$

2. Utilities		
Gas	$	$
Electric		
Water		
Sewer		
Garbage		
Telephone		
Other		
Total	$	$

3. Shelter Deduction	1st Month
a. Total Shelter (Total G1 + Total G2)	$
b. Less 50% of Line B7 – C4	
c. Excess Shelter Costs (Enter on Line C5)	$

	2nd Month
a. Total Shelter (Total G1 + Total G2)	$
b. Less 50% of Line B7 – C4	
c. Excess Shelter Costs (Enter on Line C5)	$

H. ALLOTMENT

	1st Month	2nd Month
Net Monthly Income	$	$
No. in Household		
Allotment		

I. SUPPLEMENTAL ONLY

	1st Month	2nd Month
Previous Auth.	$	$
Amount of Supp	$	$

ELIGIBILITY WORKER SIGNATURE	DATE	ELIGIBILITY WORKER SIGNATURE	DATE
SUPERVISOR SIGNATURE	DATE	SUPERVISOR SIGNATURE	DATE

HOUSEHOLD INFORMATION/DISPOSITION

APPLICATION DATE	☐ APPROVED ☐ DENIED ☐ PENDING	REASON/REMARKS

	1ST MONTH	2ND MONTH	
Classification	☐PA ☐NA ☐MIXED (NA)	☐PA ☐NA ☐MIXED (NA)	HOUSEHOLD ADDRESS
Issuance	☐ATP/HIR ☐DIRECT ☐ES	☐ATP/HIR ☐ DIRECT	
ETHNIC CODE	COMPANION CASE REFERENCE	PRIMARY LANGUAGE	AUTHORIZED REPRESENTATIVE

CHANGE WORKSHEET – For Nonbudget Changes Within the Certification Period

A. RESOURCES (Do not enter the value of excluded resources)

VERIFICATION/EXPLANATION

Cash On Hand	$
Savings Accounts	
Checking Accounts	
Stocks, Bonds, Etc.	
Nonexcluded Real Estate	
Countable Value of Licensed Vehicles (See below)	
Equity Value of Unlicensed Vehicles	
Other	
Total	$

B. ADDRESS CHANGE

C. AUTHORIZED REPRESENTATIVE CHANGE

D. HOUSEHOLD MEMBER CHANGES	WORK REGISTRATION NECESSARY	IF YES, DATE REG. IF NO, CODE	SOCIAL SECURITY NO. OR SSA 5028 DATE
1.	☐ Yes ☐ No		
2.	☐ Yes ☐ No		
3.	☐ Yes ☐ No		
4.	☐ Yes ☐ No		
5	☐ Yes ☐ No		

E. CITIZENSHIP/ALIEN VERIFICATION

F. MOTOR VEHICLE CHANGES

1.	Vehicle	Vehicle	Vehicle
Year			
Make and Model			
Estimated Value	$	$	$
Amount Owed	$	$	$
Licensed	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
2. Home, Income Producing or Handicap?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Under $4500 Per Table	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Exempt? For Household Use?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
For Work, Seek Work, School, Train?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

3. For Licensed Vehicles, the greater value (excess or equity) is the resources amount.

For Unlicensed Vehicles, the equity is the resources value.

Fair Mkt. Value		
Minus $4500		
Excess Value		

Fair Mkt. Value		
Minus Encumbr.		
Equity Value		

If under $4500 and exempt, stop here. If not, go to 3.

Type of Change					
Eligibility Worker (Initial) / Date					
Effective Date					

Form Instructions
(for Eligibility Worker)

Food Stamp Budget Worksheet - Special Medical/Shelter Deductions

Purpose:

The DFA 285-D is the worksheet used to document eligibility for food stamps for households with a member who is (1) 60 years of age or older, or (2) receiving Social Security disability payments for his/her own disability. The worksheet is used in conjunction with an application for food stamps and the DFA 285-C Food Stamp Application - Special Medical Deductions. The budget portion of the worksheet is used for computing the benefit level for one month, and for a second month if required because of an anticipated or actual change during the certification period. The change portion of the worksheet is used to record any nonbudgetary changes which occur during the certification period.

Preparation:

Enter the following identifying information on the top of the front page of the worksheet:

- Case name
- Case number

Enter the beginning and ending dates of the certification period; month and year.

Enter the effective month for the first month budget calculation and complete the budget.

Section A. Nonexempt Amounts of Gross Earned Income

1. Enter nonexempt gross earnings from employment.

2. Enter earnings from self-employment from self-employment worksheet(s).

3. Enter all training allowance received.

4. Add items A1, A2, and A3 and enter total.

5. Calculate 80 percent of the amount on Line A4 and enter.

Section B. Nonexempt Amounts of Gross Unearned Income

1. Enter nonexempt amount of all assistance grants received.

2. Enter nonexempt income from Social Security, railroad retirement, unemployment insurance, disability insurance, pensions, etc.

3. Enter all child support or alimony payments received.

4. Enter amount of all scholarships, grants, and loans from Line E4.

5. Enter all other nonexempt unearned income received by the household.

6. Add Lines B1, B2, B3, B4, and B5 and enter total.

7. Add Lines A5 and B6 and enter total.

Section C. Income Deductions

1. Enter amount of standard deduction.

2. Enter the amount of dependent care not to exceed the maximum.

3. Enter excess medical expenses from F6.

4. Add Lines C1, C2 and C3 and enter total.

5. Enter excess shelter costs from G3c.

6. Add Lines C4 and C5 and enter total.

Section D. Net Monthly Income

Subtract C6 from B7 and enter the remainder.

Section E. Educational Grants, Scholarships, Loans

Complete this section if the household has income from educational grants, scholarships or loans.

1. Enter total amount of all educational grants, etc.

2. Enter amount of tuition and mandatory fees.

3. Subtract Line 2 from Line 1 and enter remainder.

4. Divide Line 1 by number of months the educational grant, etc., is intended to cover. Enter this amount on line B4.

Section F. Medical Expenses

Complete this section if excess medical costs are claimed.

1. Add the household's portion of all recurring medical expenses and enter the total.

2. Add the household's portion of all one-month-only medical expenses and enter the total.

3. Add the household's portion of all medical expenses averaged over the certification period and enter the total. If the expense is reported within the certification period, it can be averaged over the remainder of the period.

4. Add Lines F1, F2, and F3 and enter the total.

5. Enter $35.

6. Subtract Line F5 from Line F4 and enter the remainder.

Section G. Shelter Costs

Complete this section to determine if there are excess shelter costs.

1. Enter actual housing costs and total.

2. Enter actual utility costs if household elects actual. Enter state utility standard allowance or state standard telephone deduction if applicable. Total utilities.

3. a. Enter the total of G1 and G2.

   b. Enter 50 percent of the remainder of Line B7 minus Line C4.

   c. Subtract Line 3b from 3a and enter remainder.

Section H. Allotment

Enter the net monthly income from Section D and the number of household members from the application. Using the current tables of coupon issuance enter the household's allotment.

Section I. Supplemental Only

Complete this section if the budget was calculated because of a change and resulted in a supplemental issuance. Enter previous authorization and amount of supplement.

Signature Block

Enter EW signature and date after completing budget. Enter EW supervisor signature and date after review of budget calculation and allotment.

Second-Month Budget

If a second-month budget is calculated, enter the effective month, check if the budget calculation is being made because of an anticipated or actual change, and complete as outlined for the first month budget.

Household Information/Disposition

Enter the application date and disposition of the application. If denied or pending, enter reason. Explain a concurrent approval/denial in the remarks section.

Enter the requested household information, i.e., household classification and type of issuance, ethnic code, companion case reference, primary language, household address and authorized representative.

Change Worksheet

For each nonbudgetary change, enter the date the change occurred and the date the change was reported in the verification/explanation column.

Section A. Resources

Enter any change in resource amounts and total. Determine if household still meets the maximum resource standard.

Section B. Address Change

Self-explanatory.

Section C. Authorized Representative Change

Self-explanatory.

Section D. Household Member Changes

Enter the following information for each new household member.

- Full name of the household member.
- Check (✓) if the household member is required to register for work.
- Date the household member registered for work or the work exemption code.
- Household member's Social Security number or the date the household member applied for a Social Security number.

Based on number of household members, determine new coupon allotment.

Section E. Citizenship/Alien Verification

List the document(s) used to verify legal status.

Section F. Motor Vehicle Changes

Use this section to record household motor vehicle changes. Each vehicle must be treated separately to determine its countable resource amount. Thereafter, each amount is added to determine the total vehicle resource amount.

1. Year: Self-explanatory.

   Make and Model: Self-explanatory.

   Estimated Amount: Determine from the blue book, CPI book, newspapers, etc.

   Amount Owed: Self-explanatory.

   Licensed (circle): Circle yes or no if the motor vehicle registration fees are paid for the current year. If not, skip Part 2 and go directly to Part 3.

2. For licensed vehicles, check (√) yes or no if the vehicle is used as a home, is income producing, or is a vehicle for a handicapped individual.

   Exempt? Check (√) if any vehicle is exempt for the reasons shown.

   If the fair market value of any vehicle is over $4,500 and not exempt from equity determination, proceed to Part 3.

3. For remaining licensed vehicles, the greater value (excess or equity) is the countable vehicle resource amount. Calculate as follows:

   - Enter the fair market value of the vehicle.
   - Enter $4,500.
   - Subtract $4,500 from the fair market value and enter remainder under excess fair market value.
   - Enter the fair market value again for the same vehicle.
   - Enter the amount of encumbrance.
   - Subtract the encumbrances from fair market value and enter remainder under equity value.

Change Signature Block

Complete this section each time a nonbudgetary change is recorded on the worksheet during the certification period.

- Enter the type of change, EW initials and date.

(County Stamp)

FOOD STAMP NOTICE OF ACTION AND RIGHT TO REQUEST A STATE HEARING

Case Name:
Case No.:
Worker No.:
District:
Date:

I. ☐ APPROVAL

Your application or reapplication for Food Stamps has been approved covering the period from _____ through _____.

Your benefits have been computed for your certification period based on information you have provided. Unless there are changes, you will receive the following allotment(s):

$_____ for _____ through _____; $ _____ for _____ through _____;
$_____ for _____ through _____; $ _____ for _____ through _____.

IF YOU ALSO APPLIED FOR A CASH GRANT, your Food Stamp benefits may be reduced or terminated when you receive the cash grant.

II. ☐ PENDING

Your application for Food Stamp benefits is pending. Here is what still needs to be done for us to find out if you are eligible for Food Stamps:

_____

_____

If this is done by _____, you won't have to reapply.

III. ☐ DENIAL/TERMINATION

☐ Your application/reapplication has been denied because:

☐ Effective _____, your Food Stamp benefits will be terminated because:

_____

_____

IV. ☐ CHANGE

☐ Effective _____, your Food Stamp benefits will be changed from $ _____ to $ _____ per month because _____.

Your ongoing allotment(s) will be: $_____ for _____ through _____; $_____ for _____ through _____.

☐ Failure to provide _____ by _____ will result in your benefits: ☐ Returning to the original allotment ☐ Being discontinued

V. ☐ OTHER

_____

_____

The above is required by the following laws and/or Food Stamp Manual Sections: 63–300, 63–400, 63–500.

If you have any questions, please contact me.

ELIGIBILITY WORKER	TELEPHONE NUMBER	DATE

IF YOUR BENEFITS ARE BEING REDUCED OR TERMINATED AND YOU BELIEVE THIS ACTION IS WRONG, YOUR FOOD STAMP BENEFITS MAY CONTINUE IF YOU ASK FOR A STATE HEARING WITHIN 10 DAYS OF THE MAILING DATE OF THIS NOTICE. SEE REVERSE FOR YOUR STATE HEARING RIGHTS.

Your Right to Appeal This Action

If you are dissatisfied with the action described on the other side, or any other county action, you may request a state hearing before a Hearing Officer of the State Department of Social Services. This hearing will be conducted in an informal manner to assure that everyone present is able to speak freely. Your county worker can help you request a hearing. If you decide to request a hearing you must do so WITHIN 90 DAYS OF THE DATE OF THIS NOTICE.

AFDC: If your AFDC is being reduced or stopped and you ask for a hearing within 10 days of the mailing date of this notice, you can continue to receive AFDC until the hearing.

FOOD STAMPS: If your food stamps are being reduced or stopped and you ask for a hearing within 10 days of the mailing date of this notice, your food stamps may continue until the hearing or until the end of your current period of eligibility, whichever comes first, unless you check the box at the bottom of the page.

Authorized Representative

You can represent yourself at the state hearing. You can also be represented by a friend, attorney or any other person, but you are expected to arrange for the representative yourself. You can get help in locating free legal assistance by calling the toll-free number of Public Inquiry and Response.

How to Request a State Hearing

The best way to request a hearing is to fill in and send this entire notice to:

Office of Chief Referee
State Department of Social Services
744 P Street, Mail Station 19-36
Sacramento, CA 95814

You may also request a hearing by calling the toll-free number of Public Inquiry and Response.

Public Inquiry and Response (Public Information)

Toll-Free Number: (800) 952-5253 *

Teletypewriter (TTY) only: (800) 952-5434 *

*You may have to dial "1" first.

The State Public Inquiry and Response Unit can provide you with further information about your hearing rights or files or other welfare-related matters. Assistance is also available in some languages other than English, including Spanish. You may phone, write, or come in.

Public Inquiry and Response
State Department of Social Services
744 P Street, Mail Station 16-23
Sacramento, CA 95814

Request for a State Hearing

Name _____ Phone number ( )

Address _____ City _____ State _____ Zip code _____

I am requesting a state hearing because of an action by the welfare department of _____ county related to

☐ AFDC ☐ Food Stamps

Reasons for my request:

I speak a language other than English and need an interpreter for my hearing. (The state will provide the interpreter at no cost to you.)

Language _____ Dialect _____

Food Stamps: If any portion of food stamps provided to you while awaiting the hearing decision is determined to be an overissuance, the county may recover the value of the overissuance. If you want to avoid the possibility of such an overissuance, you may check the box below:

☐ I want my food stamps terminated or reduced to the new amount determined by the county until the hearing decision. If the hearing decision is in my favor, the county will make up the food stamps I lose as a result of checking this box.

Signature _____ Date _____

The information you provide on this form is needed to process your request for a hearing, and processing may be delayed if your request is incomplete. A case file will be set up by the Chief Referee. You have a right to examine the materials that make up the file and may do so by contacting Public Inquiry and Response. Any information you provide may be shared with the county welfare department, with the U.S. Department of Health, Education, and Welfare, or the U.S. Department of Agriculture. Authority: W&IC 10950.

Form Instructions
(for Eligibility Worker)

Food Stamp Notice of Action and Right to Request a State Hearing

Purpose:

The DFA 377.1 is used by the Eligibility Worker to notify a household of the status of its food stamp case. It is used to notify households of:

- Approval actions;
- What additional information is needed for a pending case;
- Denial or termination actions;
- Changes in food stamp benefit amounts within the certification period; and,
- Reasons for the intended action(s) with the appropriate Food Stamp Manual Section.

This form may be used in certain circumstances instead of the old DFA 377.3 (Food Stamp Notice of Eligibility, Denial or Pending Status) and obsoletes DFA 377.4 (Food Stamp Notice of Adverse Action).

The backside of the DFA 377.1 explains the household's right to request a hearing and provides instructions on how to appeal the intended action. The back also provides information needed by the household to continue aid pending a hearing if food stamp or AFDC benefits are being reduced or terminated.

Note: (1) For short certification periods where a notice of expiration of certification is provided at the same time as a notice of approval, the DFA 377.3 Notice of Approval/Notice of Expiration of Certification may be provided instead of the DFA 377.1 and the DFA 377.2

(2) A change in circumstances which does not result in a change in food stamp benefits does not require a notice be provided. However, if the county chooses to provide a notice, the DFA 377.1 should be used.

Preparation:

Complete an original and two copies of the DFA 377.1 entering the following identifying information:

- Head of household's name and mailing address
- Case name
- Case number
- Worker number
- District (if applicable)
- Date

Complete the action portion of the notice by checking the heading box for each section used, and entering all other required information.

I. Approval

Check the Approval box when an application for food stamps has been approved. Enter the beginning and ending dates of the certification period, the amount of the allotment, and, if applicable, the amount and dates of a change in the allotment.

If the household subsequently receives a cash grant, and food stamp benefits are reduced or terminated, an additional notice of action is not required.

II. Pending

Check the Pending box when further information is needed on a pending application for food stamps. Identify the information needed to complete the determination of eligibility and the date it must be received.

III. Denial/Termination

Check the Denial/Termination box when an application for food stamps is denied or benefits are terminated during the certification period. Check the appropriate box in the section for the action being taken and enter the reason for the intended action.

IV. Change

Check the Change box when a change affects the food stamp benefit allotment. Check the appropriate box(es) in the section for the action being taken.

If the household fails to provide the information requested in this section and benefits are returned to the original allotment or are discontinued, an additional notice of action is not required.

V. Other

Check the Other box and enter any information to be communicated to the household.

Manual Section

Circle the appropriate general Manual Section(s) for the above action(s) and enter the applicable specific Manual Sections.

Signature Block

Enter Eligibility Worker's name, telephone number and date.

Distribution:

The original and one copy are provided to the household. The second copy is filed in the case record.

FOOD STAMP NOTICE OF EXPIRATION OF CERTIFICATION AND RIGHT TO REQUEST A STATE HEARING

(COUNTY STAMP)

Case Name:
Case No.:
Worker No.:
District:
Date:

1. Your current certification for Food Stamps will end on _____.

2. If you want to receive Food Stamps after the above date with no break in benefits, you must re-apply no later than: _____.

3. To be sure your reapplication is processed promptly you should:

☐ Fill out the attached application and mail/bring it to:

_____

☐ Appear for an interview on: _____ at: _____

_____

☐ Please call for an interview appointment.

This action is required by the following laws and/or Food Stamp Manual Sections: 63–504

If you (and/or your authorized representative) are unable to reapply for Food Stamps in person at the county welfare department and you have good reason for not being able to do this, the county welfare department can help you. The county welfare department can arrange to mail you an application and have you return it by mail, or to have an eligibility worker interview you (or your authorized representative) at home, or to conduct the interview by telephone. If you need this help, telephone the county welfare department at the number below.

You have the right to request an application from the county welfare department and to have that application accepted by the county welfare department.

IF YOU REAPPLY LATER THAN THE DATE STATED IN NO. 2 ABOVE, YOU MAY HAVE TO WAIT UP TO 30 DAYS AFTER YOU REAPPLY BEFORE FINAL ACTION IS TAKEN ON YOUR APPLICATION.

If you have any questions please contact me.

ELIGIBILITY WORKER	TELEPHONE NUMBER	DATE

You have the right to file for a state hearing if you believe you had good reason for not complying with any of the above and you presented that reason to the county, but the county welfare department did not agree with you. A request for a state hearing is on the back.

Your Right to Appeal This Action

If you are dissatisfied with the action described on the other side, or any other county action, you may request a state hearing before a Hearing Officer of the State Department of Social Services. This hearing will be conducted in an informal manner to assure that everyone present is able to speak freely. Your county worker can help you request a hearing. If you decide to request a hearing you must do so WITHIN 90 DAYS OF THE DATE OF THIS NOTICE.

AFDC: If your AFDC is being reduced or stopped and you ask for a hearing within 10 days of the mailing date of this notice, you can continue to receive AFDC until the hearing.

FOOD STAMPS: If your food stamps are being reduced or stopped and you ask for a hearing within 10 days of the mailing date of this notice, your food stamps may continue until the hearing or until the end of your current period of eligibility, whichever comes first, unless you check the box at the bottom of the page.

Authorized Representative

You can represent yourself at the state hearing. You can also be represented by a friend, attorney or any other person, but you are expected to arrange for the representative yourself. You can get help in locating free legal assistance by calling the toll-free number of Public Inquiry and Response.

How to Request a State Hearing

The best way to request a hearing is to fill in and send this entire notice to:

Office of Chief Referee
State Department of Social Services
744 P Street, Mail Station 19-36
Sacramento, CA 95814

You may also request a hearing by calling the toll-free number of Public Inquiry and Response.

Public Inquiry and Response (Public Information)

Toll-Free Number: (800) 952-5253 *

Teletypewriter (TTY) only: (800) 952-5434 *

*You may have to dial "1" first.

The State Public Inquiry and Response Unit can provide you with further information about your hearing rights or files or other welfare-related matters. Assistance is also available in some languages other than English, including Spanish. You may phone, write, or come in.

Public Inquiry and Response
State Department of Social Services
744 P Street, Mail Station 16-23
Sacramento, CA 95814

Request for a State Hearing

Name _____ Phone number ( )

Address _____ City _____ State _____ Zip code

I am requesting a state hearing because of an action by the welfare department of _____ county related to

☐ AFDC ☐ Food Stamps

Reasons for my request:

I speak a language other than English and need an interpreter for my hearing. (The state will provide the interpreter at no cost to you.)

Language _____ Dialect

Food Stamps: If any portion of food stamps provided to you while awaiting the hearing decision is determined to be an overissuance, the county may recover the value of the overissuance. If you want to avoid the possibility of such an overissuance, you may check the box below:

☐ I want my food stamps terminated or reduced to the new amount determined by the county until the hearing decision. If the hearing decision is in my favor, the county will make up the food stamps I lose as a result of checking this box.

Signature _____ Date

The information you provide on this form is needed to process your request for a hearing, and processing may be delayed if your request is incomplete. A case file will be set up by the Chief Referee. You have a right to examine the materials that make up the file and may do so by contacting Public Inquiry and Response. Any information you provide may be shared with the county welfare department, with the U.S. Department of Health, Education, and Welfare, or the U.S. Department of Agriculture. Authority: W&IC 10950.

Form Instructions
(for Eligibility Worker)

Food Stamp Notice of Expiration of Certification and Right to Request a State Hearing

Purpose:

The DFA 377.2 is used by the Eligibility Worker to notify a food stamp household of the expiration date of its current certification period, and other specific information about recertification.

The backside of the DFA 377.2 explains the household's right to request a hearing and provides instructions on how to appeal the intended action.

Note: For short certification periods where a notice of expiration of certification is provided at the same time as a notice of approval, the DFA 377.3 Notice of Approval/Notice of Expiration of Certification may be provided instead of the DFA 377.1 and the DFA 377.2.

Preparation:

For regular certification periods, the DFA 377.2 must be completed so it is received by the household not earlier than 15 days prior to, nor later than the first day of, the last month of certification. Allow two days mailing time (if mailed) in arriving at the date the household will receive the notice.

For both short and regular certification periods, complete an original and two copies of the DFA 377.2 entering the following identifying information:

- Head of household's name and mailing address
- Case name
- Case number
- Worker number
- District (if applicable)
- Date

Complete the action portion of the form as follows:

1. Enter the expiration date of the current certification period.

2. For regular certification periods, enter the fifteenth day of the last month of the certification period. For short certification periods, enter the date which is fifteen days after the date the household will receive the notice. Allow two days mailing time (if mailed) in arriving at this date.

3. Check each box, as applicable, and enter the required information.

   - Enter the address where the household should mail or bring in an application.

   - Enter the date and time the household has been scheduled for an interview.

   - Enter the name and number of the person the household should call for an interview appointment.

Signature Block

Enter Eligibility Worker's name, telephone number and date.

Distribution:

The original and one copy are provided to the household. The second copy is filed in the case record.

FOOD STAMP NOTICE OF APPROVAL / FOOD STAMP NOTICE OF EXPIRATION OF CERTIFICATION AND RIGHT TO REQUEST A STATE HEARING

(COUNTY STAMP)

Case Name:
Case No.:
Worker No.:
District:
Date:

1. ☐ Your application or reapplication for Food Stamps has been approved covering the period from _____ through _____.

Your benefits have been computed for your certification period based on information you have provided. Unless there are changes, you will receive the following allotment(s):

$_____ for _____ through _____; $_____ for _____ through _____
$_____ for _____ through _____

☐ Because you needed Food Stamp benefits right away, we postponed asking you to give us certain information. You now need to bring in or mail the following information:

_____

_____

2. If you want to receive Food Stamps after the above expiration date with no break in benefits, you must reapply no later than: _____

3. To be sure your reapplication is processed promptly you should:

☐ Fill out the attached application and mail/bring it to:

_____

☐ Appear for an interview on: _____ at: _____

_____

☐ Please call for an interview appointment.

This action is required by the following laws and/or Food Stamp Manual Sections: 63–504

If you (and/or your authorized representative) are unable to reapply for food stamps in person at the County Welfare Department and you have good reason for not being able to do this, the County Welfare Department can help you. The County Welfare Department can arrange to mail you an application and have you return it by mail, or to have an eligibility worker interview you or your authorized representative at home, or to conduct the interview by telephone. If you need this help, telephone the County Welfare Department at the number below.

You have the right to request an application from the welfare department and to have that application accepted by the County Welfare Department.

IF YOU REAPPLY LATER THAN THE DATE STATED ON NO. 2 ABOVE, YOU MAY HAVE TO WAIT UP TO 30 DAYS AFTER YOU REAPPLY BEFORE FINAL ACTION IS TAKEN ON YOUR APPLICATION.

If you have any questions, please contact me.

ELIGIBILITY WORKER	TELEPHONE NUMBER	DATE

You have the right to file for a state hearing if you believe you had good reason for not complying with any of the above and you presented that reason to the county, but the county welfare department did not agree with you. A request for a state hearing is on the back.

Your Right to Appeal This Action

If you are dissatisfied with the action described on the other side, or any other county action, you may request a state hearing before a Hearing Officer of the State Department of Social Services. This hearing will be conducted in an informal manner to assure that everyone present is able to speak freely. Your county worker can help you request a hearing. If you decide to request a hearing you must do so WITHIN 90 DAYS OF THE DATE OF THIS NOTICE.

AFDC: If your AFDC is being reduced or stopped and you ask for a hearing within 10 days of the mailing date of this notice, you can continue to receive AFDC until the hearing.

FOOD STAMPS: If your food stamps are being reduced or stopped and you ask for a hearing within 10 days of the mailing date of this notice, your food stamps may continue until the hearing or until the end of your current period of eligibility, whichever comes first, unless you check the box at the bottom of the page.

Authorized Representative

You can represent yourself at the state hearing. You can also be represented by a friend, attorney or any other person, but you are expected to arrange for the representative yourself. You can get help in locating free legal assistance by calling the toll-free number of Public Inquiry and Response.

How to Request a State Hearing

The best way to request a hearing is to fill in and send this entire notice to:

Office of Chief Referee
State Department of Social Services
744 P Street, Mail Station 19-36
Sacramento, CA 95814

You may also request a hearing by calling the toll-free number of Public Inquiry and Response.

Public Inquiry and Response (Public Information)

Toll-Free Number: (800) 952-5253 *

Teletypewriter (TTY) only: (800) 952-5434 *

*You may have to dial "1" first.

The State Public Inquiry and Response Unit can provide you with further information about your hearing rights or files or other welfare-related matters. Assistance is also available in some languages other than English, including Spanish. You may phone, write, or come in.

Public Inquiry and Response
State Department of Social Services
744 P Street, Mail Station 16-23
Sacramento, CA 95814

Request for a State Hearing

Name _____ Phone number ( )

Address _____ City _____ State _____ Zip code _____

I am requesting a state hearing because of an action by the welfare department of _____ county related to

☐ AFDC ☐ Food Stamps

Reasons for my request:

I speak a language other than English and need an interpreter for my hearing. (The state will provide the interpreter at no cost to you.)

Language _____ Dialect _____

Food Stamps: If any portion of food stamps provided to you while awaiting the hearing decision is determined to be an overissuance, the county may recover the value of the overissuance. If you want to avoid the possibility of such an overissuance, you may check the box below:

☐ I want my food stamps terminated or reduced to the new amount determined by the county until the hearing decision. If the hearing decision is in my favor, the county will make up the food stamps I lose as a result of checking this box.

Signature _____ Date _____

The information you provide on this form is needed to process your request for a hearing, and processing may be delayed if your request is incomplete. A case file will be set up by the Chief Referee. You have a right to examine the materials that make up the file and may do so by contacting Public Inquiry and Response. Any information you provide may be shared with the county welfare department, with the U.S. Department of Health, Education, and Welfare, or the U.S. Department of Agriculture. Authority: W&IC 10950.

Form Instructions
(for Eligibility Worker)

Food Stamp Notice of Approval/Food Stamp Notice of Expiration of Certification and Right to Request a State Hearing

Purpose:

The DFA 377.3 is used by the Eligibility Worker to notify a household of the approval of food stamp benefits and the expiration of the certification period. This form may be used instead of the DFA 377.1 and the DFA 377.2 for short certification periods where a notice of expiration is provided at the same time as a notice of approval.

The backside of the DFA 377.3 explains the household's right to request a hearing and provides instructions on how to appeal the intended action.

Preparation:

Complete an original and two copies of the DFA 377.3 entering the following identifying information:

- Head of household's name and mailing address
- Case name
- Case number
- Worker number
- District (if applicable)
- Date

Complete the action portion of the form as follows:

1. Enter the beginning and ending dates of the certification period, the amount of the allotment, and, if applicable, the amount and dates of a change in the allotment.

   If applicable, check the box and list the information the household must provide.

2. Enter the date which is fifteen days after the date the household will receive the notice. Allow two days mailing time (if mailed) in arriving at this date.

3. Check each box, as applicable, and enter the required information.

   - Enter the address where the household should mail or bring in an application.

- Enter the date and time the household has been scheduled for an interview.

- Enter the name and number of the person the household should call for an interview appointment.

Signature Block

Enter Eligibility Worker's name, telephone number and date.

Distribution:

The original and one copy are provided to the household. The second copy is filed in the case record.

(COUNTY STAMP)

NOTICE OF RESTORATION OF LOST FOOD STAMP BENEFITS AND RIGHT TO REQUEST A STATE HEARING

Case Name:
Case No:
Worker No:
District:
Date:

☐ A determination has been made that you are eligible for a restoration of lost food stamp benefits in the amount of $_____ for the month(s) of _____ due to:

☐ There is an unpaid claim against your household in the amount of $_____. Your entitlement to the lost benefits described above has been offset by this claim and your total entitlement has been reduced to $_____. The unpaid balance of the claim is $_____.

This entitlement will be issued to you in one lump sum, unless installments are requested by you. Please contact your worker if you would like the amount due you paid in installments.

This action is required by the following laws and/or Food Stamp Manual Sections: 63—802

If you have any questions, please contact me.

ELIGIBILITY WORKER	TELEPHONE NUMBER	DATE

If you disagree with this computation, you have the right to request a state hearing with the State Department of Social Services. See reverse for your state hearing rights.

Your Right to Appeal This Action

If you are dissatisfied with the action described on the other side, or any other county action, you may request a state hearing before a Hearing Officer of the State Department of Social Services. This hearing will be conducted in an informal manner to assure that everyone present is able to speak freely. Your county worker can help you request a hearing. If you decide to request a hearing you must do so WITHIN 90 DAYS OF THE DATE OF THIS NOTICE.

AFDC: If your AFDC is being reduced or stopped and you ask for a hearing within 10 days of the mailing date of this notice, you can continue to receive AFDC until the hearing.

FOOD STAMPS: If your food stamps are being reduced or stopped and you ask for a hearing within 10 days of the mailing date of this notice, your food stamps may continue until the hearing or until the end of your current period of eligibility, whichever comes first, unless you check the box at the bottom of the page.

Authorized Representative

You can represent yourself at the state hearing. You can also be represented by a friend, attorney or any other person, but you are expected to arrange for the representative yourself. You can get help in locating free legal assistance by calling the toll-free number of Public Inquiry and Response.

How to Request a State Hearing

The best way to request a hearing is to fill in and send this entire notice to:

Office of Chief Referee
State Department of Social Services
744 P Street, Mail Station 19-36
Sacramento, CA 95814

You may also request a hearing by calling the toll-free number of Public Inquiry and Response.

Public Inquiry and Response (Public Information)

Toll-Free Number: (800) 952-5253 *

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The State Public Inquiry and Response Unit can provide you with further information about your hearing rights or files or other welfare-related matters. Assistance is also available in some languages other than English, including Spanish. You may phone, write, or come in.

Public Inquiry and Response
State Department of Social Services
744 P Street, Mail Station 16-23
Sacramento CA 95814

Request for a State Hearing

Name _____ Phone number ( )

Address _____ City _____ State _____ Zip code _____

I am requesting a state hearing because of an action by the welfare department of _____ county related to

☐ AFDC ☐ Food Stamps

Reasons for my request:

I speak a language other than English and need an interpreter for my hearing. (The state will provide the interpreter at no cost to you.)

Language _____ Dialect _____

Food Stamps: If any portion of food stamps provided to you while awaiting the hearing decision is determined to be an overissuance, the county may recover the value of the overissuance. If you want to avoid the possibility of such an overissuance, you may check the box below:

☐ I want my food stamps terminated or reduced to the new amount determined by the county until the hearing decision. If the hearing decision is in my favor, the county will make up the food stamps I lose as a result of checking this box.

Signature _____ Date _____

The information you provide on this form is needed to process your request for a hearing, and processing may be delayed if your request is incomplete. A case file will be set up by the Chief Referee. You have a right to examine the materials that make up the file and may do so by contacting Public Inquiry and Response. Any information you provide may be shared with the county welfare department, with the U.S. Department of Health, Education, and Welfare, or the U.S. Department of Agriculture. Authority: W&IC 10950.

Form Instructions
(for Eligibility Worker)

Notice of Restoration of Lost Food Stamp Benefits and Right to Request a State Hearing

Purpose:

The DFA 377.9 is used by the Eligibility Worker to notify a food stamp household of its eligibility for restoration of lost benefits and, if applicable, of the offsetting of such benefits by unpaid claims.

The backside of the DFA 377.9 explains the household's right to request a hearing and provides instructions on how to appeal the intended action.

Preparation:

Complete an original and two copies of the DFA 377.9 entering the following identifying information:

- Head of household's name and mailing address
- Case name
- Case number
- Worker number
- District (if applicable)
- Date

Check the first box and enter the following information:

- The amount of food stamp benefits which the household is eligible to have restored.

- The month(s) for which these benefits were lost.

- The reason why the benefits were lost and the Food Stamp Manual sections governing the restoration.

Check the second box if the household has an unpaid claim which offsets all or a portion of the lost benefits to which it is entitled. Enter the following information:

- The amount of the unpaid claim.

- The remaining lost benefit entitlement, if any, after the unpaid claim has been deducted from the original entitlement, or zero if the entire entitlement was offset by the unpaid claim.

- The balance of the unpaid claim, if any, or zero if the entire amount of the unpaid claim was offset.

Signature Block

Enter Eligibility Worker's name, telephone number and date.

Distribution:

The original and one copy are mailed to the household. The second copy is filed in the case record.